Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARLINGEN MEDICAL CENTER
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2206-01

MFDR Date Received
March 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been reimbursed; however, it was not processed according to the Acute Care Hospital Fee Guidelines set forth by the TWCC. Please review this information and reprocess this claim."

Amount in Dispute: $3,553.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our CTS team has confirmed charges were priced correctly per the TX OPPS. The PPO was also confirmed and was correctly applied per the provider's contract. No additional payment is recommended at this time."

Response Submitted by: Gallagher Bassett Services, Inc., 6504 Intl Pkwy, Plano, TX 75093

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2010	Outpatient Hospital Services	$3,553.71	$93.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 provides for written notification to health care providers of contractual agreements for informal and voluntary networks.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 27, 2010

- 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIES USING REMITTANCE ADVIE REMARKS CO
- BL – PROVIDERS STATE LICENSE NUMBER IS INVALID OR WAS NOT RECEIVED.

Explanation of benefits dated October 28, 2010

- 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIES USING REMITTANCE ADVIE REMARKS CO
- 45 – (45) CHARGES EXCEED YOUR CONTRACTED LEGISLATED FEE ARRANGEMENT
- 96 – (96) NON-COVERED CHARGES
- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

Explanation of benefits dated December 30, 2010

- 1 – Please provide the appropriate CPT code, HCPCS code, or state-specific code for this service and resubmit for payment.
- 2 – The contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
- 3 – This bill was reduced in accordance with your Fee for Service contract with Coventry. For questions regarding this analysis please call (800) 937-6624
- 4 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 5 – The charge for this procedure exceeds the fee schedule allowance
- 6 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 7 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 8 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 9 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 10 – Procedure code not separately payable under Medicare and or Fee Schedule guidelines
- 11 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 12 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 13 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 14 – Recommendation of payment is based on a procedure code that best describes the services rendered
- 15 – Recommendation of payment is based on a procedure code that best describes the services rendered

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT and 2 – The contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business and 3 – This bill was reduced in accordance with your Fee for Service contract with Coventry. For questions regarding this analysis please call (800) 937-6624." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 21, 2011, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per

§134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 96365, date of service March 31, 2010,i A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Recommended payment amount is $242.34

   - Procedure code 82948, date of service March 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.54. This amount multiplied by 2 units is $9.08. 125% of this amount is $11.35. The recommended payment is $11.35.

   - Procedure code 29881, date of service March 31, 2010, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,011.84. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,207.10. This amount multiplied by the annual wage index for this facility of 0.9301 yields an adjusted labor-related amount of $1,122.72. The non-labor related portion is 40% of the APC rate or $804.74. The sum of the labor and non-labor related amounts is $1,927.46. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.18. This ratio multiplied by the billed charge of $13,260.00 yields a cost of $2,386.80. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,927.46 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $1,007.24. The allocated portion of packaged costs is $1,007.24. This amount added to the service cost yields a total cost of $3,394.04. The cost of these services exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $20.98. 50% of this amount is $10.49. The total APC payment for this line, including outlier payment, is $1,937.95. This amount multiplied by 200% yields a MAR of $3,854.92

   - Procedure code 97116, date of service March 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $24.65. This amount divided by the Medicare conversion factor of 36.0791 and multiplied by the Division conversion factor of 54.32 yields a MAR of $37.11. The recommended payment is $37.11.

   - Procedure code 97001, date of service March 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $69.25. This amount divided by the Medicare conversion factor of 36.0791 and multiplied by the Division

conversion factor of 54.32 yields a MAR of $104.26. The recommended payment is $104.26.

- Procedure code J0170, date of service March 31, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1030, date of service March 31, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250, date of service March 31, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service March 31, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010, date of service March 31, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $4,249.98. This amount less the amount previously paid by the insurance carrier of $4,156.58 leaves an amount due to the requestor of $93.40. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $93.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $93.40 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 8, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.